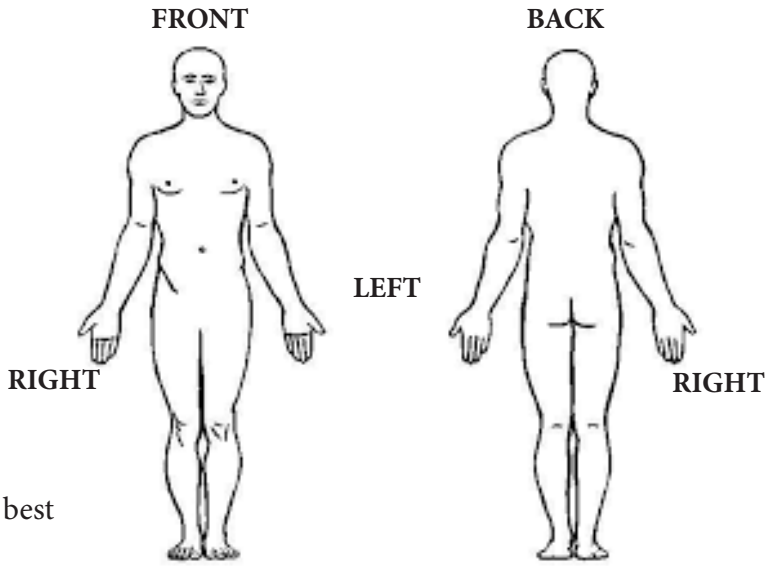
Republic Pain Specialists

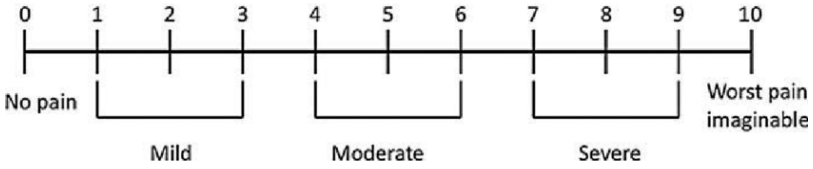
LAST, FIRST NAME: _____

DATE OF BIRTH: _____ TODAY'S DATE: _____

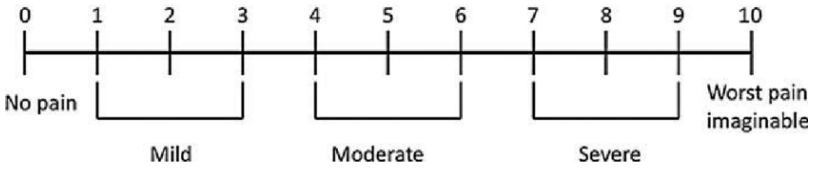
On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the **MOST.**



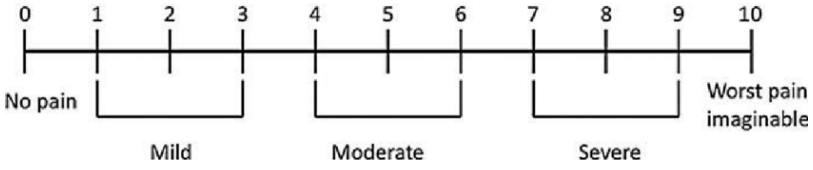
Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours.



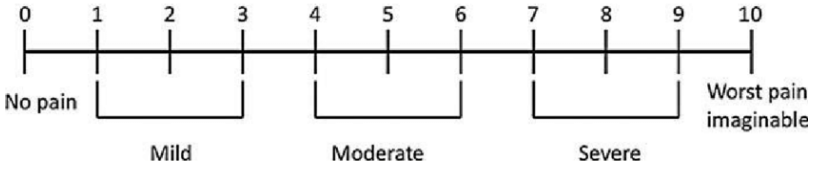
Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours.



Please rate your pain by circling the one number that best describes your pain on the **average.**



Please rate your pain by circling the one number that tells how much pain you have **right now.**



Since your pain began, has it...? ☐ Increased ☐ Decreased ☐ Stayed the Same

Describe your pain. Check all that apply.

☐ Burning ☐ Throbbing ☐ Aching
☐ Sharp ☐ Shooting ☐ Other: _____

Do you have any of these symptoms? Check all that apply.

☐ Tingling, pins & needles ☐ Numbness ☐ Muscle spasms, tightness
☐ Weakness ☐ Coldness ☐ Bowel or bladder problems
☐ Increased sweating ☐ Skin discoloration ☐ Fever or chills
☐ Infections ☐Other: _____

Which statement best describes your pain?

☐ Always present, intensity varies.
☐ Usually present, but have pain free periods lasting for one to several hours.
☐ Often present, but have pain free periods lasting for one to several hours.
☐ Occasionally present, but have pain once to several times a day, lasting a few minutes to an hour.
☐ Occasionally present for brief periods, a few seconds to a few minutes.
☐ Rarely present, pain is present eery few days or weeks.

What time of the day is your pain the worst? Check all that apply.

☐ Morning on arising ☐ Evening ☐ Bedtime
☐ Later in the morning ☐ Afternoon ☐ Night (usual sleep hours)

Do any of the following make your pain worse? Check all that apply.

☐ Coughing, sneezing ☐ Sitting ☐ Physical activity
☐ Standing ☐ Lying down ☐ Sexual activity
☐ Walking ☐ Other: _____

Do any of the following make your pain feel better? Check all that apply.

☐ Relaxation ☐ Sitting ☐ Eating
☐ Standing ☐ Lying down ☐ Walking
☐ Alcoholic drinks ☐ Sexual activity ☐ Medicines
☐ Heat ☐ Cold ☐Other: _____

Please rate the following using the scale:	**0=Not at all to 10=Completely Unable**										
Does your pain interfere with physical activity?	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfere with your ability to walk?	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfer with your personal grooming? (such as bathing, dressing, brushing your teeth)	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfere with your ability to use the bathroom?	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfere with your ability to climb stairs?	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfere with your ability to carry/handle every day objects such as a bag of groceries, pot of water, or heavy books?	0	1	2	3	4	5	6	7	8	9	10
Does your pain require you to use a cane, walker, or wheelchair, or other devices to move around?	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfere with your ability to sleep?	0	1	2	3	4	5	6	7	8	9	10
Does your pain interfere with your relations with other people?	0	1	2	3	4	5	6	7	8	9	10

How long have you had this pain? Specific date if possible. _____

How did it start? _____

_____

_____

When did you first see a doctor or nurse practitioner for your pain? _____

Please list all physicians, chiropractors, therapists and emergency room physicians you have seen for your problem and when you first saw them. (use end of form if additiona space is needed).

1. _____
2. _____
3. _____
4. _____

Have you had injections for pain relief? If yes, please include your and provider's name. Did it relieve you pain?

1. _____
2. _____

Have you had surgery for your pain? If yes, please include type of surgery, year and provider's name. Did it relieve your pain?

1. _____
2. _____
3. _____
4. _____

Which of the following have you used for pain relief? Did it relieve your pain?

Therapy	Pain Relief		Currently Using	
☐ Physical Therapy	Yes	No	Yes	No
☐ Hypnosis	Yes	No	Yes	No
☐ Bio-Feedback	Yes	No	Yes	No
☐ TENS	Yes	No	Yes	No
☐ Acupuncture	Yes	No	Yes	No
☐ Chiropractic	Yes	No	Yes	No
☐ Heat	Yes	No	Yes	No
☐ Bed Rest	Yes	No	Yes	No
☐ Traction	Yes	No	Yes	No
☐ Osteopathic	Yes	No	Yes	No
☐ Counseling/Psychotherapy	Yes	No	Yes	No
☐ Yoga/Pilates	Yes	No	Yes	No
☐ Meditation	Yes	No	Yes	No
☐ Other: _____	Yes	No	Yes	No
☐ Other: _____	Yes	No	Yes	No

Past Medications

What pain medications have you used in the **PAST**? Did they work?

- ☐ Opioids: morphine, oxycodone, hydrocodone, hydromorphone, buprenorphine, Amitriptyline,
- ☐ NSAIDS: Tylenol, Ibuprofen, Naproxen, Aspirin,
- ☐ Antidepressants: Amitriptyline, Cynmbalta, Gabapentin, Lyrica, Topiramate, Topamax, Duloxetine, Effexor, Venlafaxine
- ☐ Herbals/Vitamins

Have you had any ORAL or INJECTED steroids, cortisone, or prednisone in the past? If so, when?

Current Medications

List all medications you currently take. Include all prescription & non-prescription such as aspirin, Tylenol, vitamins, home remedies, herbal or homeopathic supplements, etc. Please list all blood thinners (Coumadin, aspirin, Vitamin E, Plavix, garlic, etc.), cortisone, and prednisone you are taking.

Medication Name	Dose	Frequency	Date Started

ALLERGIES: **List all drug, food & environmental allergies:**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Past Pain History (Give dates for injuries)

☐ No other pain problems

☐ Motor vehicle injuries. _____

☐ Work related injuries _____

☐ Any other injuries or trauma _____

☐ Headaches _____

☐ Neck pain _____

☐ Arm or shoulder pain _____

☐ Upper back pain _____

☐ Lower back pain _____

☐ Chest pain _____

☐ Leg pain _____

☐ Joint pain _____

☐ Arthritis _____

☐ Other pain _____

Past Surgical History (include year, hospital and physician's name)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

What hobbies do you have or have had in the past, and can you still participate in them?

Circle all that apply now or in the past.

Current weight: _____lbs

Current height: _____

Family Medical History (check all that apply)

☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Diabetes

☐ Heart Attack ☐ Bleeding Disorder ☐ Asthmas ☐ Muscle Disease

Social History:

Where have you lived most of your life?_____

Highest grade completed?_____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed How long? _____

Do you live with: ☐ Spouse ☐ Significant Other ☐ Parents ☐ Alone ☐ Other _____

Number and age of children? _____

If married or equivalent, which best describes your relationship?

☐ Completely Satisfactory ☐ Satisfactory ☐ Tolerable ☐ Intolerable ☐ No opinion

Has your pain changed your relationship with your family? ☐ Yes ☐ No

Smoking History:

Have you ever smoked tobacco? ☐ Yes ☐ No If yes, quit date:_____

Do you smoke now? ☐ Yes ☐ No If yes, when did you begin smoking? _____

How many packs per day? _____ Cigars per day? _____ Pipe? _____

Alcohol History:

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____

Have you ever had problems with alcohol? ☐ Yes ☐ No

If yes, explain: _____

_____

Caffeinated Drinks:

Do you consume drinks with caffeine? ☐ Yes ☐ No If yes, how many per day? _____

Illicit (street) Drugs:

Do you use any street drugs/marijuana? This is very important! ☐ Yes ☐ No

If yes, what & how much? _____

_____

Work History:

Employed: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Disabled

List the main jobs you have held in the past 10 years? _____

_____

Describe your current or last job: _____

How long have you held this job? _____

When ws the las tday you worked "full duty"? _____

If currently working, how many hours per week do you work? _____

Does your work involve any of the following?

☐ Standing	How long at a time? _____	☐ Walking	How long at a time? _____
☐ Driving	How long at a time? _____	☐ Lifting	How long at a time? _____
☐ Sitting	How long at a time? _____	☐ Vibration	How long at a time? _____

☐ Exposure to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise ☐ None

Have you missed much work because of your current or past pain or illness?	☐ Yes	☐ No
Is your job stressful?	☐ Yes	☐ No
Do you like your job?	☐ Yes	☐ No
Do you like your supervisor?	☐ Yes	☐ No

If you are not working, are you receiving wage compensation, diability pay or workman's comp? ☐ Yes ☐ No

Do you have an attorney or lawyer helping you with a lawsuit about disability, worker's compensation, injury, or a pain-related legal matter? ☐ Yes ☐ No

Metabolic:

☐ Diabetes
If yes, how long? _____ ☐ Insulin ☐ Oral medications

☐ Thyroid Disease
If yes, weight ☐ loss ☐ gain _____lbs., time frame _____

☐ Recurrent Fever ☐ General weakness ☐ Swollen glands ☐ Fatique
☐ Sweating episodes ☐ Intolerance to heat or cold ☐ Frequent infections ☐ Chills

☐ Exercise What? _____ How often? _____

Neurological:

☐ Stroke ☐ Seizures/Epilepsy ☐ Frequent/recurrent headaches ☐ Weakness
☐ Tremors/Tics ☐ Anxious/Agitated ☐ Faining/Blackouts/Dizziness ☐ Dizziness
☐ Problems concentrating/thinking ☐ Walking/Balance difficulties
☐ Paralysis or numb/tingling areas ☐ Problems with memory or confulsion

Cardiovascular:

☐ Heart Attack ☐ High Blood Pressure ☐ Heart Surgery/Valve Replacement ☐ Murmur
☐ Chest Pain ☐ Swelling feet/hands ☐ Mitral valve prolapse ☐ Leg pain
☐ Heart Failure ☐ Poor circulation ☐ Rheumatic Fever ☐ Palpitations
☐ Cold limbs ☐ Varicose Veins ☐ Shortness of breath

Pulmonary:

☐ Asthmas ☐ Pneumonia ☐ Emphysema or COPD ☐ Bronchitis
☐ Wheezing ☐ Frequent Cough ☐ Obstructive Sleep Apnea/CPAP ☐ TB

Gastrointestinal:

☐ Heatburn or Reflux ☐ Generalized Arthritis
☐ Hepatitis or Yellow Jaundice ☐ Liver Disease
☐ Irritable Bowel ☐ Hiatal Hernia
☐ Unable to control bowels

Musculoskeletal:

☐ Muscle Cramps ☐ Generalized Arthritis ☐ Stiff/Swollen Joints ☐ Neck Pain
☐ Foot Pain ☐ Upper Back Pain ☐ Lower Back Pain ☐ Muscle Spasms
☐ Osteoporosis ☐ Heel Spurs ☐ Difficulty Walking ☐ Gout
☐ Rheumatoid Arthitis ☐ Fibromyalgia Syndrome
☐ Muscle Weakness: Where? _____

Psychological:

☐ Depression
☐ Learning Disability
☐ Nervousness
☐ Bipolar disorder
☐ Dementia
☐ Agitated
☐ Confusion
☐ Previous Psychiatric Treatment
By Whom? _____
Number of Visits? _____
Most Recent Visit? _____
☐ Suicidal thoughts
☐ Anxiety or Panic Attacks
☐ Attention Deficit Disorder (ADD or ADHD)
☐ Excessive Worrying
☐ Memory Prolems
☐ Alzheimers Disease
☐ Concentration Problems
☐ Childhood: ☐ Happy ☐ Unhappy ☐ Neither
☐ Flashbacks
☐ Physical Violence
☐ Sexual Abuse
☐ Arrests or Jail Sentence
☐ Attempted Suicide When? _____

Other:

☐ Blood Disorders
☐ Skin Problems
☐ Lupus
☐ Genital Problems
☐ Kidney Stones
☐ Easy bruising or bleeding
☐ Cancer - Where/What type?_____
☐ HIV or Hepatitis
☐ Urinary Incontinence/Frequency/Difficulty
☐ Frequent urinary infections

What would you like to accomplish with your visits here? What would you do if you had less pain?

_____

_____

_____

_____

_____

_____